

EXHIBIT 7

Managed Care Pharmacy Practice

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Managed Care Pharmacy Practice

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other entities, the parties typically agree that such disputes will be submitted to and settled by arbitration in accordance with an authority such as the Bermuda Arbitration Act of 1986, which is considered to be the sole means by which disputes will be resolved

ASO—administrative services only, typically a portion of the per member per month rate that is performed either by a payer or provider; a contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and does not assume any risk; services usually include claims processing but may include other services such as actuarial analysis or utilization review; *see also* ERISA

assignment of benefits—the payment of medical benefits directly to a provider of care rather than to a member; generally requires either a contract between the health plan and the provider, or a written release from the subscriber to the provider allowing the provider to bill the health plan; the transfer of one's interest or policy benefits to another party

assumption of financial risk—the risk an HMO bears on behalf of its members; according to CFR-42, each HMO must assume full financial risk on a prospective basis for the provision of basic health services, except that it may obtain insurance or make other arrangements to cover the following: for the cost of providing an aggregate value of more than \$5,000 to an enrollee in any year; the cost of legitimate out-of-area care; for not more than 90% of the amount by which its costs for any fiscal year exceed 115% of its income; and to cover risk for its participating providers

attrition rate—disenrollment expressed as a percentage of total membership; a plan with 40,000 members with a 2% attrition rate would need to gain 800 new members each month to retain the initial 40,000 covered lives

average cost per claim—a financial amount, representing the sum of the medical charge and administrative charge for services provided within the categories of admissions, physician services, and outpatient claims

AWP—average wholesale price; the standard charge for a pharmacy item; derived by taking the average cost of the item to a pharmacy as charged by a large representation of pharmacy wholesale suppliers (for items not otherwise being sold at a discount)

AWP laws—any willing provider laws; requires managed care organizations to grant network enrollment to any provider who is willing to join, as long as they meet provisions outlined in the plan; the central

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Managed Care Pharmacy



*Principles
and
Practice*

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and, therefore, would not cover, for instance, smoking cessation products or programs or cholesterol self-testing kits.

Although employers may generally understand pharmacy a bit better than they used to, they do not understand it as well as they need to. They are, however, learning quickly about how pharmaceutical products are used and abused. Employers have customarily maintained a trusting attitude toward doctors, who well knew how to write appropriate prescriptions for all their patients, and toward retail pharmacists, who evaluated and responded to clinical messages. Employers also trusted the administrators of their plans, confident that they were being handled according to their designs. However, employers are finding that "it ain't necessarily so" and that their trust may have been misplaced. In some cases involving PBMCs, the employers' interests and those of their employees were not well served.

HOW EMPLOYERS CAME TO FOCUS ON DRUG PRICE AND NOT ON PHARMACEUTICAL-ASSOCIATED COSTS

Historical Focus of the Sales Process

"All employers want AWP minus such and such," say PBMCs. However, financiers are focusing on price precisely because of what they have been sold by PBMCs. This focus on price is perhaps a result of the PBMCs' failure to present data to employers or to identify properly the factors that drive increases. Some of these factors can be managed by PBMCs, while others cannot. Similarly, employers can manage some factors through plan design changes, while some they cannot (e.g., changes in their covered population). However, the focus on price also may be, perhaps, a result of the sales process itself. When PBMCs start switching their tune to "Now we are going to focus on clinical outcomes and disease management," employers and other financiers will start to switch too. However, they will probably remain uneasy about PBMCs' ability to deliver for quite some time.

How PBMCs View Themselves: Managing Drugs, Not Health Care

A second reason financiers came to focus on price was due to the way the PBM industry viewed itself, which was as a manager of drugs rather than a manager of the overall cost of health care. Now, PBMCs talk about

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outcomes, clinical care, and overall costs, but financiers remember that quality care was rarely their main interest in the past. Some employers that evaluate the products that PBMCs place on their formularies may even question their motives. Are the employers and their employees the client, or is it the drug manufacturers?

They Thought It Was an Easy Comparison

Employers thought price was an easy comparison, but they did not understand what AWP really was. They thought it was an average and that it was wholesale, which sounded better than retail. They thought it was a consistent price that someone else paid to buy drugs and, therefore, an easy way to compare one offer against another. Furthermore, the PBMCs did not tell them otherwise. Eventually, employers learned that AWP was neither an average nor was it wholesale; neither was it a price—except for the price, less discounts, that they paid.

No Other Basis Presented to Measure Results

The last point, in terms of understanding how employers and other financiers came to focus on price, is that few vendors presented a good alternative upon which to base buying decisions. Some vendors are beginning to offer alternative payment models such as capitation, but PBMCs need to be able to validate results of lower prices. As part of a very competitive world, corporations must deliver value to their customers, and when they buy—in this case, from the PBMC—they also want to receive value. Therefore, PBMCs must show employers their ability to deliver value. Those who do not can expect to be greeted with skepticism.

WHAT EMPLOYERS REALLY WANTED ALL ALONG

To Hire Specialty Managers Where It Made Sense

All along, employers wanted to buy from specialty managers, where it made financial and quality-of-care sense. Pharmacy benefit management companies grew, in part, because they did what others, insurers among them, could not. Today, some PBMCs manage health care far better than HMOs that try to do it without their help. Other chapters describe the problems resulting from management fragmentation under the drug carve-

out plan, but another focus might be, "How do we then integrate drug data with the medical records and share it with others?" The most interesting initiatives currently under way are those seeking to carve out pharmacy and then reintegrate its information into overall patient data and care management—back into the HMO, for instance. This means that all of the information captured, through a pharmacy plan, about a patient can be used to improve overall patient care.

To Manage Health Care Costs with Assistance from Specialty Managers

Employers really wanted to manage health care and its costs; however, carving out the pharmacy benefit has made their lives much more difficult, adding, as it does, a new vendor that supplies them with a new set of data. They never really intended to manage pharmacy in and of itself.

To Provide Benefits Employees Want at Prices They Can Afford

The employers' goal was to offer an employee benefits program that would attract and retain workers, one which also would help plan sponsors reach their corporate goals. Of course, employers wanted a plan they could afford; otherwise, they would go out of business.

To Have a Healthy, Productive Workforce

Fundamentally, employers wanted a healthy, productive workforce, which is why they provided health care benefits. In the employer marketplace today, a growing new benefit is wellness and prevention coverage. The challenge here is about keeping people well, and not just about footing the bill when preventable illnesses occur or addressing compliance issues. Lifestyle changes could reduce employee reliance on medications and possibly make them more productive workers. This new way of thinking in the employer arena can be seen when companies downsize, often resulting in pharmaceutical costs that hit new highs as employees try to cope with stress. If employers have the necessary data and information, they can design campaigns to address foreseen situations and prevent problems. They rely upon, for instance, both PBMCs and pharmacists, who, because of their technology and easy patient access, have an opportunity to provide cost-effective help.